

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (x) Yes ( ) No
Requestor's Name and Address Jacob Rosenstein, MD 800 West Arbrook Blvd. Suite 150 Arlington, Texas 76015	MDR Tracking No.: M4-03-6511-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company P O Box 12029 Austin, Texas 78711-2029 Box 54	Date of Injury:
	Employer's Name: Sedco Drilling Company, LTD.
	Insurance Carrier's No.: 99C0000316325

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/12/03	02/12/03	99214	\$71.00	\$71.00

## PART III: REQUESTOR'S POSITION SUMMARY

"...insurance carrier failed to pay code 99214, stating 'documentation does not support the specific level of service billed.' We disagree with these determinations about the report dated 2-12-03. That is easily meeting the requirement of a 'moderate' appointment."

## PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response states, "It is the carrier's position that a detailed examination and history of moderate complexity is not documented." Denials listed on the EOBs state, "N-Documentation does not support the service billed. Carriers may not reimburse the service at another billing codes' values per rule 133.301(B). A revised CPT code or documentation to support the service billed may be submitted."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The provider submitted documentation that supports the requirements of services billed per MFG E/M (IV).  
Therefore, based on this information reimbursement is recommended.

<b>PART VI: DETAIL FINDINGS (If needed)</b>							
				<b>Total Left Column:</b>			\$0.00
				<b>Total Amount Due:</b>			\$71.00

PART VII: COMMISSION DECISION AND ORDER								
<p>Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of <b>\$71.00</b>. The Division hereby <b>ORDERS</b> the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.</p> <p><b>Ordered by:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border-bottom: 1px solid black; text-align: center; padding-bottom: 5px;"> <div style="border: 1px solid black; height: 40px; margin: 0 auto; width: 100px;"></div> </td> <td style="width: 33%; border-bottom: 1px solid black; text-align: center; padding-bottom: 5px;"> <div style="border: 1px solid black; height: 40px; margin: 0 auto; width: 100px;"></div> </td> <td style="width: 33%; border-bottom: 1px solid black; text-align: center; padding-bottom: 5px;"> <div style="border: 1px solid black; height: 40px; margin: 0 auto; width: 100px;"></div> </td> </tr> <tr> <td style="text-align: center; padding-top: 5px;">Authorized Signature</td> <td style="text-align: center; padding-top: 5px;">Michael Bucklin Typed Name</td> <td style="text-align: center; padding-top: 5px;">02/10/05 Date of Order</td> </tr> </table>			<div style="border: 1px solid black; height: 40px; margin: 0 auto; width: 100px;"></div>	<div style="border: 1px solid black; height: 40px; margin: 0 auto; width: 100px;"></div>	<div style="border: 1px solid black; height: 40px; margin: 0 auto; width: 100px;"></div>	Authorized Signature	Michael Bucklin Typed Name	02/10/05 Date of Order
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Authorized Signature	Michael Bucklin Typed Name	02/10/05 Date of Order						

**PART VIII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_